

# WHEN JUSTICE SHOULD PRECEDE GENEROSITY: THE CASE AGAINST CHARITABLE IMMUNITY IN ARKANSAS\*

## I. INTRODUCTION

Davis Smith checked into Generous Health Hospital, a registered charitable institution, for a simple procedure.<sup>1</sup> However, complications occurred when the doctor punctured an organ, sending Mr. Smith into cardiac arrest. After emergency surgery, the seemingly simple operation was complete. Although Mr. Smith survived, the Smiths' lives have entirely changed. The doctor's avoidable error left Mr. Smith with worsened heart problems. He lost his job and his health insurance, causing the Smiths to pay hundreds of thousands of dollars in follow-up care—diminishing their life savings—until Mr. Smith could receive disability benefits.

“When things like this happen in the hospital, questions arise: Who’s responsible? If treatment makes things worse . . . who pays? The answer, it seems, is that it depends.”<sup>2</sup> In states that recognize charitable immunity, including Arkansas, the hospital would be immune from tort liability should the court recognize their charitable status.<sup>3</sup> Unfortunately, this compounds the financial, physical, and emotional burdens already experienced by patients and families such as the Smiths.<sup>4</sup> This

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1. Shefali Luthra, *When Something Goes Wrong at the Hospital, Who Pays?*, KAISER HEALTH NEWS (Nov. 11, 2015), [<https://perma.cc/UYR3-ZGAN>]. The scenario that follows in the Introduction is based on the real-life consequences a husband and wife faced. Their story can be read at the article cited in this Comment.

2. *Id.*

3. 1 HOWARD W. BRILL & CHRISTIAN H. BRILL, ARKANSAS LAW OF DAMAGES § 33:2 (2020).

4. See *The Quality of Mercy: “Charitable Torts” and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1387, 1390 (1987).

Comment discusses various aspects of the modern hospital and examines charitable immunity's incompatibility with modern law.

First, Part II explains the historical justifications for immunity and presents the doctrine's landscape in the United States. Part III examines the role precedent plays in continuing to adhere to the rule of immunity. Part IV takes an in-depth approach of the big business of hospitals by evaluating various financial aspects of charitable hospitals. Part V explores the reality of charitable immunity falling out of touch with concepts of modern law. Part VI takes a more specific look at the application of the law in Arkansas, and Part VII concludes by encouraging the Arkansas Supreme Court to consider the imbalance of justice and generosity imposed by the doctrine.

## II. BACKGROUND

Charitable immunity, a common law doctrine that precludes liability of charitable institutions for negligence, has a tumultuous history.<sup>5</sup> Many scholars credit Massachusetts as the first state to recognize the doctrine in 1876.<sup>6</sup> However, this is not necessarily true. Prior to 1876, Arkansas had twenty years of precedent protecting assets held in trust by charitable institutions.<sup>7</sup>

In 1856, the Arkansas Supreme Court acknowledged the concept of charitable immunity when it prevented the sale of a plot of land because the land was donated to the Methodist

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5. Christa S. Clark, *Tort Law—Tort Immunity for Non-Profits—Is the Charitable Immunity Defense Becoming an Offense for Arkansas Hospitals?* *George v. Jefferson Hosp. Ass'n*, 337 Ark. 206, 987 S.W.2d 710 (1999), 22 U. ARK. LITTLE ROCK L. REV. 125, 128, 132 (1999) (“Unlike [the doctrine’s] turbulent history found elsewhere, . . . in Arkansas [it] has remained steadfast.”).

6. See, e.g., Paul T. O’Neill, *Charitable Immunity: The Time to End Laissez-Faire Health Care in Massachusetts Has Come*, 82 MASS. L. REV. 223, 225 (1997) (stating that “[i]n the United States the theory of charitable immunity first was espoused in Massachusetts”); *The Quality of Mercy*, *supra* note 4, at 1383-84 (1987) (“Massachusetts . . . fashioned . . . a blanket doctrine of charitable immunity. . . . [Other] states . . . followed suit.”).

7. See *infra* note 8 and accompanying text. Compare BRILL, *supra* note 3, § 33:2 (“Arkansas has recognized the doctrine of charitable immunity since 1856. . . . [It] is an affirmative defense.”), with O’Neill, *supra* note 6, at 225 (stating that the Massachusetts case that first recognized the doctrine was decided in 1876). See generally Grissom v. Hill, 17 Ark. 483, 1856 WL 609 (1856). Arkansas courts did not at that time use the later recognized title of “charitable immunity.”

Protestant Church for “purely charitable” purposes.<sup>8</sup> The court found this “purely charitable” purpose clause prevented the selling of the property because “carry[ing] out the intention of the donor” is the most important duty of those who hold property in trust.<sup>9</sup> Thus, while not directly utilizing the “charitable immunity” title, Arkansas recognized the doctrine’s substance.<sup>10</sup> Despite being the first state to utilize charitable immunity, Arkansas is now one of the last states clinging to the archaic doctrine.<sup>11</sup>

The formal—and foundationally—weak rise of charitable immunity began in Massachusetts and relied on English precedent.<sup>12</sup> *Holliday v. Parish of St. Leonard*, from which American jurisprudence developed, was subsumed from dicta of two previously overturned cases.<sup>13</sup> Further, as the doctrine was gaining traction in the United States, *Holliday* was overturned.<sup>14</sup> Moreover, even if *Holliday* had not been overturned, its facts are distinguishable from the factual background of charitable

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8. *Grissom*, 17 Ark. at 484, 488-89, 491, 1856 WL 609, at \*2, \*5, \*7.

9. *Id.* at 484-89, 1856 WL 609, at \*2-5.

10. See BRILL, *supra* note 3, § 33:2 (“The rationale behind [charitable immunity] is that agencies, entities and trusts created and maintained exclusively for charity should not have their assets diminished to satisfy a judgment . . .”).

11. Janet Fairchild, Annotation, *Tort Immunity of Nongovernmental Charities—Modern Status*, 25 A.L.R. 4th 517, II. B., § 6 (1983). This section of the annotation lists those states where immunity has been partially or wholly retained. Arkansas is one of four states referenced along with Massachusetts, South Carolina, and Virginia.

12. O’Neill, *supra* note 6, at 225-26 (“[A]s the sole authority for [Massachusetts’] new rule, [the justice] misinterpreted and then relied on the dicta of the previously overruled English case . . .”).

13. *Id.* (explaining that “the *Holliday* decision upon which [the justice] relied as justification for his adoption of charitable immunity was, itself, inherently flawed. The *Holliday* decision misinterpreted two English cases, *The Feoffees of Heriot’s Hospital v. Ross* and *Duncan v. Findlater* . . .”); see also *President of Georgetown Coll. v. Hughes*, 130 F.2d 810, 815-17 (D.C. Cir. 1942) (“The foundation of immunity in this country is the dictum of . . . *The Feoffees of Heriot’s Hospital v. Ross* . . . *Duncan v. Findlater* . . . uttered a similar dictum, and this was followed in *Holliday v. St. Leonard* . . . . However, the dictum of *Duncan v. Findlater* was overruled by *Mersey Docks Trustees v. Gibbs*, . . . and the ruling of *Holliday v. St. Leonard* was reversed by *Foreman v. Mayor of Canterbury* . . . .” (citations omitted)).

14. O’Neill, *supra* note 6, at 227 (“[W]hen [the judge] created the doctrine of charitable immunity in Massachusetts, English law already was well settled . . . [and] the most basic rule of tort law, liability for negligent conduct, prevailed in England . . . .”); see also *Hughes*, 130 F.2d at 815-17 (“In this state of the English decisions, Massachusetts adopted the repudiated rule of *Holliday v. St. Leonard* in *McDonald v. Massachusetts General Hospital*, and Maryland followed *Heriot’s case* in *Perry v. House of Refuge*.” (citations omitted)).

immunity cases in American jurisprudence.<sup>15</sup> Yet, by the 1940s, approximately forty states had adopted the doctrine.<sup>16</sup>

Charitable immunity's faulty foundation was exacerbated by each state's theory in adopting the doctrine.<sup>17</sup> The most prominent theory is the trust fund theory,<sup>18</sup> which purports to protect assets held in trust by adhering to donative intent.<sup>19</sup> Presumably, this does not include utilizing monies to satisfy a judgment. Other states relied upon the following theories when adopting charitable immunity:

- (1) **Inapplicability of Respondeat Superior:** immunity from negligence as long as the charitable hospital was not negligent in hiring the employee because the employee was not under the control of the charitable hospital and, thus, the negligence was not caused by the charitable hospital.<sup>20</sup>
- (2) **Implied Waiver of Liability:** accepting the benefit of services from the charitable hospital waives liability and assumes the risk that negligence may occur.<sup>21</sup>

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15. O'Neill, *supra* note 6, at 226 (“[*Holliday*’s] holding was directed specifically at the creation of a public duty rule to protect public employees and servants from liability. The case did not create a liability shield for charitable trust funds.”). *Holliday* focused on an employee’s, who was hired by trustees appointed under the Public Road Act thus creating a public duty, negligent maintenance of a public road. *Holliday v. Par. of St. Leonard*, 142 Eng. Rep. 769, 769-70 (1861). In contrast, charitable immunity focuses on establishing immunity for charitable institutions. See BRILL, *supra* note 3, § 33:2.

16. Clark, *supra* note 5, at 129 (“The charitable immunity doctrine continued to expand to other jurisdictions in the United States, and by the early 1940s, over forty states accepted full charitable immunity as the prevailing view.”).

17. See *infra* note 23; see also *Hughes*, 130 F.2d at 817-22.

18. See *supra* note 9 and accompanying text; *The Quality of Mercy*, *supra* note 4, at 1383 n.9.

19. *The Quality of Mercy*, *supra* note 4, at 1384 (explaining that “charitable expenditures were said to be limited by the intent of the donor, which in turn was said not to include paying damages in tort”); Fairchild, *supra* note 11, at I., § 2 (“[F]unds of a charity are held in trust . . . [and] the charitable donor’s intent would be thwarted by [diversion of these funds to tort claimants], and donors might thereby be discouraged from charitable beneficence.”).

20. Fairchild, *supra* note 11, at I., § 2 (explaining that charitable institutions are immune from liability “where the alleged negligence was that of its employees or servants, but not where the negligence complained of was . . . negligent selection of the negligent servant or employee, since such actions are considered as having been done by the charitable institution itself and not by its servants or agents”).

21. See, e.g., O'Neill, *supra* note 6, at 228 (explaining that “implied waiver[] was founded on the premise that the beneficiaries of charities receive goods and services free of charge, provide no consideration in the bargain and impliedly assume all the risks of harm from the charity by accepting its munificence, and thus waive their rights to recourse”);

- (3) **Theory of Public Policy:** charitable hospitals should be protected from bankruptcy by avoiding monetary judgments when they have, historically, operated from donations and merely tried to do good by serving the poor.<sup>22</sup>

These theories were soon criticized by courts and legal scholars.<sup>23</sup> The doctrine's demise began with its abrogation in *President and Directors of Georgetown College v. Hughes*.<sup>24</sup> In dismissing each theory, the D.C. Circuit recognized that although charitable institutions offer kindness, “[c]harity . . . cannot be careless. When it is, it ceases to be kindness and becomes actionable wrongdoing.”<sup>25</sup>

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Fairchild, *supra* note 11, at I, § 2 (explaining that “the beneficiary of a charitable organization has, by accepting the benefits of the charity, impliedly waived liability or assumed the risk of negligence”).

22. O’Neill, *supra* note 6, at 228-29 (stating that “imposition of liability on charities for their torts could drive them to bankruptcy, cause them to lose donors and volunteers and ultimately close their doors entirely and cease to offer the benefits of their work to the public. . . . [M]ost hospitals were, indeed, strictly, charitable institutions subsisting mainly on donations and providing medical care almost exclusively for the poor.”).

23. Clark, *supra* note 5, at 130 (“Overall, the charitable immunity defense became fragmented, varying widely state to state, with each jurisdiction creating various exceptions and levels of abandonment.”); *see, e.g.*, O’Neill, *supra* note 6, at 227-29 (“[T]hese theories were logically inconsistent, legal fictions, erroneous misapplications, or at best, poor excuses for depriving a victim from just and needed compensation.”); *The Quality of Mercy*, *supra* note 4, at 1387-89 (“[T]he notion that a charitable trust is precluded by the intent of its donors from paying out damages—is now plainly anachronistic. . . . [M]aintain[ing] that victims of charitable torts had implicitly waived liability by accepting charitable service[] was never more than fiction.”).

24. *See, e.g.*, *The Quality of Mercy*, *supra* note 4, at 1385 (“[T]he accumulated weight of these exceptions brought the doctrinal structure of charitable immunity to the point of collapse. Inspired in part by Judge Rutledge’s lengthy criticism in *President of Georgetown College v. Hughes*, American courts moved rapidly away from charitable immunity.”); O’Neill, *supra* note 6, at 230 (stating that “[f]inally, . . . Justice Rutledge removed the last cornerstone justifying charitable immunity in his opinion in *President and Directors of Georgetown College v. Hughes*”).

25. *President of Georgetown Coll. v. Hughes*, 130 F.2d 810, 813, 818-22, 824-25 (D.C. Cir. 1942). Justice Rutledge noted that: “Five states . . . have no decisions on the subject. Eleven apparently adhere to full immunity . . . . Three certainly, and apparently a fourth, have imposed unqualified liability. . . . In seven states strangers and paying beneficiaries may recover . . . . The trend in ten states . . . seems clearly toward unqualified responsibility. . . . In thirteen of the remaining states, apparently, strangers are allowed to recover, but beneficiaries are denied relief.” *Id.* at 818-21. Justice Rutledge goes on to describe that no matter what theory a state chose to adhere to in adopting the doctrine, “[the theories] are merely different names for the same idea . . . . In any event[,] the result is a departure from general . . . principles of liability.” *Id.* at 825.

Counter arguments for the trust fund and public policy theories are explained by the similarities of charitable hospitals and big businesses.<sup>26</sup> Historically, charities operated without liability insurance, largely supported by donations, and primarily served the poor; however, the modern reality is that charitable hospitals have significant financial funding and both hospitals and patients are insured.<sup>27</sup> In addition, the public policy theory has been criticized because it does not align with tort law's policies of deterrence and compensation<sup>28</sup> when charitable institutions are not held legally accountable and plaintiffs bear injury upon injury.<sup>29</sup>

The theories of respondeat superior and waiver of liability have been targeted as “departure[s] from general . . . principles of liability.”<sup>30</sup> The exemption of the respondeat superior theory does not correspond with the trend of liability for negligence committed in the scope of employment.<sup>31</sup> The employee is under the control of the charitable institution, and thus, the employer should be held liable.<sup>32</sup> The trend was, and is, to distribute losses against the institution rather than leave the victim wholly to bear the loss.<sup>33</sup>

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26. Fairchild, *supra* note 11, at I., § 2 (stating that the trust fund theory is “inconsistent with modern reality, since modern charity or philanthropy is ‘big business’”).

27. O’Neill, *supra* note 6, at 228-30; *Hughes*, 130 F.2d at 823-24; *see also* RESTATEMENT (SECOND) OF TORTS § 895E cmt. c (AM. L. INST. 1979) (“The development of liability insurance has made it quite unlikely that donors would fail to recognize it as a legitimate expense of operation.”); Fairchild, *supra* note 11, at I., § 2, II.A., § 3 (stating that “liability insurance is widely and inexpensively available”); *The Quality of Mercy*, *supra* note 4, at 1395 (“Charities in modern times [are] better organized and wealthier than their nineteenth century counterparts. . . . [I]nsurance [has] become more widely available.”).

28. STUART M. SPEISER ET AL., 1 AMERICAN LAW OF TORTS § 1:3 (Monique C. M. Leahy, ed. 2020) (“The fundamental policy purposes of the tort compensation system are compensation of innocent parties . . . and deterrence of wrongful conduct.”).

29. O’Neill, *supra* note 6, at 229, 234 (“An innocent victim might literally have to bear the entire burden of both his treatment and his injury alone.”).

30. *Hughes*, 130 F.2d at 824-25.

31. *See id.* at 814, 827.

32. *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 27, § 895E cmt. c (The inapplicability of respondeat superior “runs counter to the whole law of vicarious liability . . . which is not limited to profitable enterprises and rests rather upon the employment of the servant, the employer’s direction and control over his conduct and the furtherance of an enterprise that he has set in motion.”).

33. *See Hughes*, 130 F.2d at 824, 827 (describing “the injustice of giving benefit to some at the cost of injury to others and of the injured individual’s having to bear the loss wrongfully inflicted upon him, at a time when the direction of the law is toward social distribution of losses through liability for fault”).

The application of the waiver of liability theory requires a “knowing, voluntary and informed decision,” which is difficult to obtain from an injured person.<sup>34</sup> Requiring this of an individual without bargaining power and without the requisite medical knowledge unreasonably places the burden of liability on the one who is incapable of knowing the difference—the physician knows the reasonable standard of care and is expected to live up to that standard.<sup>35</sup>

Consequently, more than seventy-five percent of states have abolished the antiquated doctrine.<sup>36</sup> However, some states, including Arkansas, still recognize a form of partial immunity. Although the Arkansas Supreme Court continues to adhere to its original reasoning for the doctrine’s adoption, the doctrine has transformed from protecting charitable assets from judgment (immunity from judgment) to immunity from suit, back to immunity from judgment, and, currently, back to immunity from suit, effectually limiting the right of redress to injured plaintiffs and leaving them “whipsawed” by the court.<sup>37</sup> Further, the court has stated that application of the doctrine should be given a “narrow construction”; however, in overbroadly applying an

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34. O’Neill, *supra* note 6, at 228 (“In the field of medical care, a knowing, voluntary waiver often is impossible where . . . a patient is unconscious, immature or otherwise incapacitated.”).

35. RESTATEMENT (SECOND) OF TORTS, *supra* note 27, § 895E cmt. c (“The [patient] in fact understands and expects that he will be treated with reasonable care; and those who undertake to render . . . services are held, in general, to the standard of reasonable conduct in doing so.”); *see also* O’Neill, *supra* note 6, at 228 (“[W]hen people present for services or medical care at a hospital, most frequently they are ill or . . . in desperate need of assistance. Often, their condition prevents them from seeking assistance elsewhere such that they cannot and do not argue about the terms of their treatment.”).

36. *See generally* GEORGE GLEASON BOGERT ET AL., *BOGERT’S THE LAW OF TRUSTS AND TRUSTEES* § 402 (2020) (“By the end of the 20th Century, more than three quarters of the states had abolished or limited the doctrine of charitable immunity . . . .”); Fairchild, *supra* note 11 at II.A., § 3 to II.B., § 6 (listing those states and the corresponding authority that has completely abrogated or partially retained the doctrine). Both of these sources provide a compiled list of states and the corresponding case or statute which has changed the law of charitable immunity within the state. Notably, almost every state has accomplished abolition of the doctrine through the judiciary. *See* Fairchild, *supra* note 11, at II.A. § 4[a], [b]. In comparing the sources, generally, the information is the same. However, when updates in the law within a state had occurred, one source provided a more recent case or statute. *See id.* at Table of Cases, Laws, and Rules.

37. *Downing v. Lawrence Hall Nursing Ctr.*, 2010 Ark. 175, at 10-11, 14, 16-17, 369 S.W.3d 8, 15-18; *Davis Nursing Ass’n v. Neal*, 2019 Ark. 91, at 5, 570 S.W.3d 457, 460; *Low v. Ins. Co. of N. Am.*, 364 Ark. 427, 437-40, 220 S.W.3d 670, 677-80 (2005); *George v. Jefferson Hosp. Ass’n*, 337 Ark 206, 211, 987 S.W.2d 710, 712-13 (1999).

eight-factor test to determine whether an institution qualifies as a charity, the court has not followed its own instruction.<sup>38</sup> The factor test has led to charitable status becoming a mixed matter of law and fact.<sup>39</sup>

Compounding these inconsistencies, applying the eight-factor test has led to piecemeal litigation.<sup>40</sup> Generally, a denial of a motion for summary judgment is not appealable.<sup>41</sup> Limited exceptions are provided for sovereign immunity, while charitable immunity has been judicially expanded.<sup>42</sup> When the jury is

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38. *George*, 337 Ark. at 217-18, 987 S.W.2d at 716 (Brown, J., dissenting) (“[W]e . . . give the doctrine [of charitable immunity] a very narrow construction.”); *see also* Clark, *supra* note 5, at 143. This Comment analyzes the *George* decision in detail and explains that in the dissent, Justice Brown, “noted that the majority’s approach abandoned the *Williams* mandate of narrow construction for the defense of charitable immunity and therefore broadened the defense by refusing to narrowly apply the *Masterson* factors.” Clark, *supra* note 5, at 143; *see also* *Masterson v. Stambuck*, 321 Ark. 391, 400-01, 902 S.W.2d 803, 809-10 (1995). The Arkansas Supreme Court adopted this eight-factor test set forth by the Eastern District of Virginia in 1993. *Masterson*, 321 Ark. at 400-01, 902 S.W.2d at 809. The test, composed of eight factors, all of which are illustrative, and not considered to be exhaustive, include:

- (1) whether the organization’s charter limits it to charitable . . . purposes; (2) whether the organization’s charter contains a “not-for-profit” limitation; (3) whether the organization’s goal is to break even; (4) whether the organization earned a profit; (5) whether any profit or surplus must be used for charitable . . . purposes; (6) whether the organization depends on contributions and donations for its existence; (7) whether the organization provides its services free of charge to those unable to pay; and (8) whether the directors and officers receive compensation.

*Id.* at 400-01, 902 S.W.2d at 809-10.

39. *See Davis*, 2019 Ark. 91, at 8, 570 S.W.3d at 462 (“If the existence of charitable immunity turns on disputed factual issues, then the jury may determine the facts, and the . . . court will subsequently determine whether those facts are sufficient to establish charitable immunity.”). When facts are *undisputed*, charitable status is a matter of law decided by the judge. *Id.* at 6, 570 S.W.3d at 461. When facts are *disputed*, the question of charitable status is to be presented to the jury. *Id.*, 570 S.W.3d at 461. Yet, when facts are *undisputed* but subject to *differing legal interpretations*, the question of charitable status is a matter of law to be decided by the court, and when “reasonable persons would not reach different conclusions based upon those undisputed facts,” summary judgment should be granted. *Id.* at 6-7, 570 S.W.3d at 461 (quoting *Anglin v. Johnson Reg’l Med. Ctr.*, 375 Ark. 10, 21, 289 S.W.3d 28, 35 (2008)).

40. *See id.* at 9-10, 570 S.W.3d at 462-63 (Baker, J., dissenting) (stating that “the purpose of a final order is to avoid piecemeal litigation”).

41. Ark. R. App. P.–Civ. 2(a)(2). When an order determines the action, such as summary judgment, and prevents a judgment from being appealed, or discontinues the action, the losing party may appeal. *See* Appellees’ Supplemental Abstract and Brief at ARG 3, *St. Bernards Cmty. Hosp. v. Cheney*, No. CV-19-324 (Ark. Ct. App. July 1, 2019), [<https://perma.cc/39Q4-REQP>] [hereinafter Brief for Appellee].

42. *See* Ark. R. App. P.–Civ. 2(a)(10); *Davis*, 2019 Ark. 91, at 1 n.1, 570 S.W.3d at 459 n.1. *But see* Brief for Appellee, *supra* note 41, at ARG 3-4.



instructed to decide the institution's charitable status, a bifurcated trial must be set, thus prolonging the underlying question of negligence.<sup>43</sup>

As predicted, the state of the law has led to collateral litigation, increased expenses, clogged dockets, and immense confusion.<sup>44</sup> Arkansas plaintiffs have repeatedly called for charitable immunity's abrogation,<sup>45</sup> yet the court continues to remain "lost in the fog" of its muddled history while refraining from forgoing "the anomaly that the institutional doer of good [has] exemption from responsibility for its wrong, though all others must pay."<sup>46</sup> Adherence to the doctrine results in "great injury" and must be abolished.<sup>47</sup>

### III. THE ROLE OF THE JUDICIARY

The American legal system allows for changes in the law through the judiciary, which interprets the law, and the legislature, which makes the law.<sup>48</sup> How much power each respective branch of government holds has long been a point of contention.<sup>49</sup> Interestingly, the doctrine of charitable immunity

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43. See Brief for Appellee, *supra* note 41, at ARG 2.

44. Brian Brooks, *Clayborn and Scamardo: Two Nails in the Coffin of Charitable Immunity*, 39-SUM ARK. LAW. 16, 18-19 (2004) (explaining that inefficiencies would likely arise from the Arkansas Supreme Court decisions in *Clayborn* and *Scamardo*).

45. *E.g.*, *Downing v. Lawrence Hall Nursing Ctr.*, 2010 Ark. 175, at 6, 369 S.W.3d 8, 13; *Ark. Elder Outreach of Little Rock, Inc. v. Nicholson*, 2013 Ark. App. 758, at 6-7, 2013 WL 6706095, at \*3.

46. *President of Georgetown Coll. v. Hughes*, 130 F.2d 810, 815, 828 (D.C. Cir. 1942).

47. *Scamardo v. Jagers*, 356 Ark. 236, 242, 149 S.W.3d 311, 314 (2004) (noting that the court "does have the power to overrule prior decisions, [but] it is necessary, as a matter of public policy, to uphold those decisions unless a great injury or injustice would result").

48. See *Marbury v. Madison*, 5 U.S. 137, 147, 177 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is." It must "expound and interpret [the] rule" subject to "such exceptions, and under such regulations as congress shall make.").

49. See *id.* at 174 ("If it had been intended to leave it in the discretion of the legislature to apportion the judicial power between the supreme and inferior courts according to the will of that body, it would certainly have been useless to have proceeded further than to have defined the judicial power . . . . If congress remains at liberty to give this court appellate jurisdiction, where the constitution has declared their jurisdiction shall be original; and original jurisdiction where the constitution has declared it shall be appellate; the distribution of jurisdiction, made in the constitution, is form without substance.").

illustrates courts' authority to both establish *and* overrule legal rules through case law.<sup>50</sup>

### A. Whose Province of Power

A lingering issue in charitable immunity's history has been which branch of government should alter the doctrine given that it is grounded in public policy, which is generally the legislative branch's prerogative.<sup>51</sup> However, public policy decisions have never been in the hands of "the [l]egislature alone,"<sup>52</sup> and this is especially true when an individual's rights are questioned.<sup>53</sup> For example, charitable immunity cuts off the rights of the injured to seek relief, adding injury upon injury by making the individual bear the burden of what more appropriately should be borne by the charitable institution.<sup>54</sup>

Many state supreme courts have acted upon their duty to overrule the injustice of charitable immunity because the judiciary is given the power to protect against "individual hurt."<sup>55</sup>

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50. *Miss. Baptist Hosp. v. Holmes*, 55 So. 2d 142, 152 (Miss. 1951) (stating that "the courts have created an immunity, which, under all legal theories, is basically unsound . . . . [W]hen the reason for the existence of a declared public policy no longer obtains, the court should, without hesitation, declare that such policy no longer exists, and especially where the same has been created by the courts instead of by the Legislature.").

51. *See Pierce v. Yakima Valley Mem'l Hosp. Ass'n*, 260 P.2d 765, 774 (Wash. 1953). The Washington Supreme Court, when abolishing charitable immunity, explained that

[t]he public policy upon which [charitable immunity] is based is legislative in character. . . . It pertains . . . to broad economic and social considerations. . . . Many courts have expressed the view that it is for the legislature, and not for the courts, to establish a policy exempting charities from tort liability. . . . However, having previously undertaken this function, and having now concluded that our court-declared policy is no longer valid, there seems to be no compelling reason why we must wait for legislative action.

*Id.* at 774-75.

52. *Parish v. Pitts*, 244 Ark. 1239, 1242, 429 S.W.2d 45, 47 (1968) (stating that "[c]onsiderations of public policy are not and never have been for determination by the Legislature alone").

53. *Id.* at 1242-43, 429 S.W.2d at 47 (emphasizing that it is even more important for the judiciary to consider public policy decisions when "the individual's rights are put in question by governmental activity").

54. *See supra* note 29 and accompanying text.

55. *Parish*, 244 Ark. at 1242, 429 S.W.2d at 47; *see, e.g., Harris v. Young Women's Christian Ass'n*, 237 N.E.2d 242, 245 (Ind. 1968) ("[T]he duty of this Court is to repudiate the doctrine of charitable immunity and in view of the fact that it is a Court-made rule, it is hereby abolished by this Court without waiting for the intervention of the Legislative Branch of Government."); *Albritton v. Neighborhood Ctrs. Ass'n for Child Dev.*, 466 N.E.2d 867, 871 (Ohio 1984) ("[T]his court not only has the power but the duty and responsibility to

The Arkansas Supreme Court has recognized that denying someone the ability “to sue for an alleged wrong . . . minimize[s] protection of the public interest.”<sup>56</sup> Further, the court has emphasized that “the most practical way to protect” an individual’s interest when tortious conduct occurs is to provide the individual an opportunity to seek legal relief.<sup>57</sup>

Moreover, charitable immunity was a rule based on a public policy surmised by the judiciary.<sup>58</sup> Notably, the Arkansas Supreme Court has stated that “[j]udicially created actions can be judicially abolished.”<sup>59</sup> Without waiting for the legislature to act, the court itself abolished another form of immunity—municipal immunity.<sup>60</sup> Thereafter, the legislature stepped in,<sup>61</sup> making it reasonable to assume the same could occur should the court abolish charitable immunity.

Nevertheless, it is unrealistic to expect the legislature to correct “a problem of judge-made” law.<sup>62</sup> Inaction from the

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evaluate [charitable] immunity . . . .”); *Parish*, 244 Ark. at 1242, 429 S.W.2d at 47 (explaining that “it is to the judiciary that the power of government is given to provide protection against individual hurt”).

56. *Walt Bennett Ford, Inc. v. Pulaski Cnty. Special Sch. Dist.*, 274 Ark. 208, 211, 624 S.W.2d 426, 428 (1981). While it is not that individuals lack standing to sue hospitals, the principle can be analogized to charitable immunity in that, even though individuals may be permitted to bring a claim against the hospital at the outset of the case, once charitable immunity is granted, the individual cannot sue the hospital for the harm that occurred. Individuals are already at a vulnerable state due the injury suffered, and now, granting charitable immunity eliminates any protection the judicial system has to offer, thus exposing them to distress that is not rightfully placed.

57. *Id.*, 624 S.W.2d at 428 (recognizing that “the most practical way to protect the public interest is to allow [aggrieved parties] to seek judicial review of any alleged wrong”).

58. *See, e.g., Abernathy v. Sisters of St. Mary’s*, 446 S.W.2d 599, 606 (Mo. 1969) (“The judicial branch of government need not call to, or wait upon, the legislative branch to change a rule of law which the judicial branch itself created.”); *Noel v. Menninger Found.*, 267 P.2d 934, 941 (Kan. 1954) (“[Charitable] immunity . . . was introduced by the courts without legislative sanction, and that it is, therefore, for the courts to undo what they have themselves brought about.”).

59. *Treiber v. Hess*, 301 Ark. 97, 98, 782 S.W.2d 43, 44 (1990).

60. *Thompson v. Sanford*, 281 Ark. 365, 369, 663 S.W.2d 932, 935 (1984) (explaining that the court abolished municipal immunity after several years of prompting the legislature to do so).

61. *Id.*, 663 S.W.2d at 935 (explaining that shortly after abolishing municipal immunity, the legislature established its own public policy stance on the issue).

62. *Parish v. Pitts*, 244 Ark. 1239, 1242, 429 S.W.2d 45, 46 (1968) (“Despite the Court’s invitation for legislative action ten years ago there has quite understandably been no comprehensive legislative consideration . . . . It could not realistically be expected that a problem of judge-made or ‘lawyers’ law’ could or would be given the necessary time and attention by the Legislature. It operates basically in a sixty-day biennial session, necessarily

legislature is not a sufficient justification for the hesitation to abrogate a judicially created doctrine that contradicts modern public policy. The Arkansas Supreme Court must abolish charitable immunity.

## B. The Role of Precedent

Although the Arkansas Supreme Court has the authority to abolish charitable immunity, another hurdle remains—*stare decisis*. The court has relied on this fundamental legal principle to continue to enforce charitable immunity.<sup>63</sup> While *stare decisis* may provide stability and predictability, it is imperative that it not overshadow the harsh realities of unsound policy.<sup>64</sup> Courts have grappled with *stare decisis* and continue to conclude that when an underlying policy no longer exists, neither should the rule of law it once supported.<sup>65</sup>

Historically, charitable immunity has operated as a rule of property.<sup>66</sup> Rules of property relate to the law of real estate and provide stability in the property title system.<sup>67</sup> They

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crowded with more pressing and immediate problems of economics, taxation, the allocation of the proceeds thereof, and the myriad other interests affecting the general welfare of the people of the State.”).

63. See generally *Low v. Ins. Co. of N. Am.*, 364 Ark. 427, 220 S.W.3d 670 (2005).

64. See *Parish*, 244 Ark. at 1252, 429 S.W.2d at 52 (“Th[e] policy of adhering to precedent to give predictability to the law, and to avoid unsettling things, is fundamental to the common law. So too is the power to overrule a line of decisions, even those under which property rights were acquired. . . . Precedent governs until it gives a result so patently wrong, so manifestly unjust, that a break becomes unavoidable. Any rule of law not leading to the right result calls for rethinking and perhaps redoing.”).

65. See, e.g., *Kojis v. Drs. Hosp.*, 107 N.W.2d 131, 133-34 (Wis. 1961) (“The rule of *stare decisis*, however desirable from the standpoint of certainty and stability, does not require us to perpetuate a doctrine that should no longer be applicable in view of the changes in present day charitable hospitals.”); *Bing v. Thunig*, 143 N.E.2d 3, 9 (N.Y. 1957) (“If, instead, adherence to precedent offers not justice but unfairness, not certainty but doubt and confusion, it loses its right to survive, and no principle constrains us to follow it.”).

66. See, e.g., *Low*, 364 Ark. at 433-34, 220 S.W.3d at 675 (reiterating charitable immunity has been described as a rule of property); *Helton v. Sisters of Mercy of St. Joseph’s Hosp.*, 234 Ark. 76, 80-81, 351 S.W.2d 129, 131 (1961) (stating that charitable immunity has become a rule of property which should not be disturbed).

67. *Spruill v. Spruill*, 241 Ark. 808, 818, 410 S.W.2d 606, 611 (1967) (Fogleman, J., dissenting) (Rules of property are “settled legal principle[s] governing the ownership and devolution of property[.] . . . the descent, transfer, or sale of property, and the rules which affect the title and possession thereto.” (quoting *Gibson v. Talley*, 206 Ark. 1, 7, 174 S.W.2d 551, 554 (1943))); *Kirkham v. Malone*, 232 Ark. 390, 396, 336 S.W.2d 46, 49 (1960) (Rules of property govern “the law of real estate . . . [S]uch rules are based upon technicalities . . .

predominately govern *real property* because, were such rules not followed, “chaos . . . would be the result and *property values* would diminish in direct relationship to the degree of instability existing in the law of this or any other state as it might be applied to real property.”<sup>68</sup> Monetary donations, although held in trust, are more akin to gifts—that is, personal property—and such a rule of property, if prospectively abolished, would not lead to chaos.<sup>69</sup> Further, the court has explicitly stated that other areas of immunity do not invoke rules of property because “the law of torts does not affect ownership or devolution of title.”<sup>70</sup> Thus, resorting to *stare decisis* gives weight to a rule that holds “no great weight in the field of tort law.”<sup>71</sup>

Precedent should no longer govern when its result is “so patently wrong” and “manifestly unjust.”<sup>72</sup> Charitable immunity is a “rule of law [that does] not lead[] to the right result,” and the Arkansas Supreme Court must declare that as so.<sup>73</sup>

#### IV. THE FINANCIAL CIRCUMSTANCES OF MODERN CHARITIES

The Arkansas Supreme Court has implied that if “compelling public policy” exists, the court would abolish the doctrine itself.<sup>74</sup> Charitable immunity’s abrogation in other states is supported by the transition of the modern hospital to operating

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[which] have been continued because of the ever-present need for stability and predictability in this field of the law.”)

68. See *Kirkham*, 232 Ark. at 396, 336 S.W.2d at 49 (emphasis added).

69. See *Parish v. Pitts*, 244 Ark. 1239, 1253-54, 429 S.W.2d 45, 52-53 (1968).

70. *Id.* at 1253, 429 S.W.2d at 52. Although devolution of property, such as donations or money, are not necessarily involved within municipal immunity, the court still stated that they were “not here faced with a rule of property, for the law of torts does not affect ownership or devolution of title. Contracts and wills are not drawn in reliance upon it.” *Id.*, 429 S.W.2d at 52. Aside from the donations received by charitable hospitals, the underlying issue relates to tort law, that often being a medical malpractice claim in negligence.

71. *Id.*, 429 S.W.2d at 52 (stating that “[o]rdinarily then the doctrine of *stare decisis* is of no great weight in the field of tort law”).

72. *Id.* at 1252, 429 S.W.2d at 52 (“Precedent governs until it gives a result so patently wrong, so manifestly unjust, that a break becomes unavoidable.”).

73. *Id.*, 429 S.W.2d at 52 (“Any rule of law not leading to the right result calls for rethinking and perhaps redoing.”).

74. *Cook v. Wausau Underwriters Ins.*, 299 Ark. 520, 522, 772 S.W.2d 614, 616 (1989) (“Since the legislature has not indicated any intent to overrule our longstanding precedents, and we find no *compelling public policy* reason for doing so, we decline the invitation to overrule our prior decisions.” (emphasis added)).

as a big business that is fully capable of sustaining tort liability.<sup>75</sup> This compelling public policy has existed for some time, and, therefore, the court should abolish charitable immunity in light of the modern evolution of charitable hospitals.<sup>76</sup>

### A. The Business of Charitable Hospitals

Hospitals and other healthcare related organizations have experienced significant growth, accounting for half of all charitable organizations and contributing to more than three quarters of all charitable expenses.<sup>77</sup> The American Hospital Association reported that of more than six thousand hospitals, almost half are nonprofit—more than both for-profit and state and local government hospitals combined.<sup>78</sup>

Charitable hospitals impact the economy both directly and indirectly and are economic drivers similar to any other business—employing hundreds of people, owning vast amounts of assets, and operating from increasing revenues yet providing little charity care.<sup>79</sup> In Arkansas, for-profit and nonprofit hospitals combined contribute more than \$11 billion of economic activity,<sup>80</sup> with a direct and indirect economic impact producing

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75. *See, e.g.*, *Granger v. Deaconess Hosp. of Grand Forks*, 138 N.W.2d 443, 448 (N.D. 1965) (noting that “much of modern charity or philanthropy is ‘big business’ in its field. It therefore has a capacity for absorption of loss which did not exist in the typical nineteenth century small hospital or college.”); *Mullikin v. Jewish Hosp. Ass’n of Louisville*, 348 S.W.2d 930, 932 (Ky. 1961) (describing charity as “big business” (quoting *Parker v. Port Huron Hosp.*, 105 N.W.2d 1, 12 (1960))).

76. *Albritton v. Neighborhood Ctrs. Ass’n for Child Dev.*, 466 N.E.2d 867, 871 (Ohio 1984) (“[T]his court not only has the power but the duty . . . to evaluate [charitable immunity] in light of reason, logic and the actions and functions of the relevant entities in the twentieth century.”).

77. GEORGE MORRIS ET AL., *THE FINANCIAL HEALTH OF THE UNITED STATES NONPROFIT SECTOR: FACTS AND OBSERVATIONS* 4 (2018), [<https://perma.cc/RU2S-4SEL>] (“Hospitals, Health and Human Services . . . , and Educational Institution nonprofits account for nearly half of the organizations in the sector and 80% of its expenditures.”).

78. AM. HOSP. ASS’N, *FAST FACTS ON US HOSPITALS* (2020), [<https://perma.cc/6SSC-TNEC>] [hereinafter *AHA, FAST FACTS*].

79. AM. HOSP. ASS’N, *HOSPITALS ARE ECONOMIC ANCHORS IN THEIR COMMUNITIES* (2018), [<https://perma.cc/6AYU-WPUA>] (“Hospitals[] [e]mploy nearly 5.9 million people[] [a]re one of the top sources of private-sector jobs[] [and] [p]urchase \$903 billion in goods and services from other businesses. . . . [This] create[s] additional economic value for the community. Overall, hospitals[] [s]upport 16.5 million total jobs, or one of 9 jobs, in the U.S. [and] [s]upport almost \$3.0 trillion in economic activity.”).

80. *See* ARK HOSP. ASS’N, *2019 GUIDE TO HOSPITAL STATISTICS* 35, 44-45 (2019), [<https://perma.cc/XMU8-2T3N>] [hereinafter *ARK. HOSP. ASS’N, 2019 STATISTICS*].

almost 90,000 jobs.<sup>81</sup> As one article described it, “[t]he standard nonprofit hospital doesn’t act like a charity any more than Microsoft does — they also give some stuff away for free.”<sup>82</sup> Like any other business, charitable hospitals should be held accountable for their negligence.

When the Arkansas Supreme Court abolished municipal immunity, it likened municipalities to corporate bodies—the same is true for modern hospitals.<sup>83</sup> In any corporation that is well-run, tort liability should be a small expense.<sup>84</sup> Should it be otherwise, tort liability benefits the public safety and public knowledge by exposing continued tortious conduct. In addition, it is likely that such an expense could be minimized because, like other businesses, charitable hospitals have the same avenues of law in court.<sup>85</sup> Thus, it is reasonable to require that charitable hospitals pay all of their expenses, including those which may arise from tort judgments.<sup>86</sup>

Hospitals provide immense assistance to individuals and families by providing medical care to the suffering and contributing to overall health and education. However, while charitable institutions are classified as not-for-profit, significant attention is given to operating them at a profit.<sup>87</sup> More often than

81. *Id.*

82. Elisabeth Rosenthal, *Benefits Questioned in Tax Breaks for Hospitals*, N.Y. TIMES, Dec. 17, 2013, at A18, [<https://perma.cc/7VKL-YRV6>] [hereinafter Rosenthal, *Benefits Questioned*] (questioning the value of the tax exemptions that many nonprofit hospitals take advantage of because of their charitable status, which has been a growing debate among health care management, regulators, and politicians).

83. *See Parish v. Pitts*, 244 Ark. 1239, 1247, 429 S.W.2d 45, 49 (1968) (“[M]unicipalities are . . . corporate bodies, capable of much the same acts as private corporations . . .”).

84. *See id.* at 1248, 429 S.W.2d at 49 (“In the private sector tort liability is a small item in the budget of any well run enterprise and should prove to be proportionately no greater for the municipality . . .”).

85. *See id.*, 429 S.W.2d at 49-50 (explaining that tort liability should prove to be a small expense because businesses “have available to [them] the same defenses and means of spreading the risk”).

86. *See Mullikin v. Jewish Hosp. Ass’n of Louisville*, 348 S.W.2d 930, 932 (Ky. 1961) (“Charit[able] [hospitals] today [are] a large-scale operation with salaries, costs and other expenses similar to business generally. It makes sense to say that this kind of charity should pay its own way, not only as to its office expenses but as to the expense of insurance to pay for torts as well.” (quoting *Parker v. Port Huron Hosp.*, 105 N.W.2d 1, 13 (1960))).

87. *Rabon v. Rowan Mem’l Hosp. Inc.*, 152 S.E.2d 485, 499 (N.C. 1967) (stating that “[e]ven though public hospitals are not operated for private gain, every effort is made to operate them at a [p]rofit”).

not, the “commitment to charity is dwarfed by [the] preoccupation with profits.”<sup>88</sup>

### 1. Revenue

Despite the idea that paying damages would negatively impact the continued operation of charitable hospitals, both the number of charitable hospitals and their revenues have substantially increased across all states, even those that have abrogated charitable immunity long ago.<sup>89</sup> Of the registered 1.5 million nonprofit organizations, the health sector accounts for more than 50% of overall growth, and much of the revenue reported was in the form of patient charges and government grants.<sup>90</sup>

Since 1999, the number of hospitals has experienced approximately a 5% growth—increasing from 4,956 to 5,198.<sup>91</sup> Notably, by 1999 most states had already abolished the doctrine, yet overall, the hospital industry has expanded.<sup>92</sup> Neither the number of hospitals, nor their viability, has been negatively impacted in states that have abrogated charitable immunity.<sup>93</sup>

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88. Rosenthal, *Benefits Questioned*, *supra* note 82.

89. See AHA, FAST FACTS, *supra* note 78 and accompanying text; see also Flagiello v. Pa. Hosp., 208 A.2d 193, 197 (Pa. 1965) (“According to one who has made a study of the [increase in hospitals], there were only 178 hospitals in the United States in 1873. Since then, hospitals have been growing in number, size, expansion and service. Entering a hospital was at one time regarded with a measure of awe. Doing so now has become almost a commonplace occurrence, although a highly beneficial one.” (footnote omitted)).

90. See Brice S. McKeever, *The Nonprofit Sector in Brief 2018*, NAT’L CTR. FOR CHARITABLE STATS. (Dec. 13, 2018) [https://perma.cc/4CH8-MKJ7] (“Approximately 1.56 million nonprofits were registered with the Internal Revenue Service (IRS) in 2015, an increase of 10.4 percent from 2005.”); I.R.S., STATISTICS OF INCOME: CHARITIES AND OTHER TAX-EXEMPT ORGANIZATIONS, TAX YEAR 2015 (2018), [https://perma.cc/Q9KQ-LWB6] [hereinafter I.R.S., STATISTICS OF INCOME] (“Over 73 percent of revenue reported by charitable organizations on Form 990 came from program services, which include payments to organizations in the form of tuition, patient charges, admission fees, etc. . . . Contributions, gifts, and grants comprised the other major sources of charitable revenue. While many contributions came from the public . . . well over half were in the form of government grants.”); McKeever, *supra* (“The growth for the health sector, \$343.3 billion, accounts for over three-fifths of the growth of the entire nonprofit sector between 2005 and 2015 (\$554.6 billion).”).

91. *State Health Facts: Total Hospitals*, KAISER FAM. FOUND., [https://perma.cc/KRF8-E4XN] (last visited Feb. 22, 2020).

92. *Id.*; *supra* note 36 and accompanying text.

93. See *supra* note 91 and accompanying text; *infra* note 95.



Immunity does not improve a hospital's ability to function or progress, it only hinders an individual's right to be made whole.

Further, although hospitals file a small percentage of charitable tax returns, they are amongst the class of organizations that account for nearly 90% of the entire charitable sector's revenue.<sup>94</sup> Hospital revenues significantly increased in the last decade "from \$689.3 billion in 2005 to \$977.1 billion in 2015," experiencing "the largest dollar growth of" the charitable industry.<sup>95</sup>

In Arkansas, revenues from various charitable hospitals range from \$16.7 million to \$896.5 million, while expenses average from \$17 million to \$884.1 million.<sup>96</sup> Although not all hospitals operate at a significant profit when compared to other companies, there is still no evidence to substantiate the notion that the number of charitable hospitals will decrease by imposing full liability.<sup>97</sup> Quite the contrary, as noted above, charitable hospitals are increasing and thriving despite being subject to tort liability.<sup>98</sup> Thus, courts should not accept that hospitals could not financially sustain tort liability.

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94. See I.R.S., STATISTICS OF INCOME, *supra* note 90 ("Large organizations, especially hospitals and universities, dominated the financial activity of the charitable sector. Charities with assets over \$10 million filed only 8 percent of the returns for Tax Year 2015, but they accounted for . . . 87 percent of revenue reported. While small charities filed nearly 60 percent of returns, they represented a negligible amount of the sector's financial holdings and activity.").

95. See McKeever, *supra* note 90 ("Revenues for hospitals and primary care facilities, in particular, increased from \$689.3 billion in 2005 to \$977.1 billion in 2015 after adjusting for inflation, by far the largest dollar growth of any subsector during this period.").

96. See *Baptist Health*, HOSPITALFINANCES.ORG, [https://perma.cc/6SV4-VW43] (last visited February 20, 2020) [hereinafter *Baptist Health*]; *St. Bernards Community Hospital*, HOSPITALFINANCES.ORG, [https://perma.cc/V3UC-L9DN] (last visited Feb. 20, 2020) [hereinafter *St. Bernards Community Hospital*].

97. See *Granger v. Deaconess Hosp. of Grand Forks*, 138 N.W.2d 443, 447 (N.D. 1965) ("There are also reasons which take force away from the fears of dissipation and deterrence of donations. No statistical evidence has been presented to show that the mortality or crippling of charities has been greater in states which impose full or partial liability than where complete or substantially full immunity is given.").

98. *Id.* at 447-48 ("Charities seem to survive and increase in both [states that have and do not have charitable immunity], with little apparent heed to whether they are liable for torts or difference in survival capacity.").

## 2. Assets

The modern charitable hospital engages in activities and has resources never contemplated when immunity was first established.<sup>99</sup> Hospitals operate with substantial capital and invest billions of dollars in assets including real estate and medical equipment. Of a total of \$90.7 billion dollars invested in the healthcare sector, approximately \$56.7 billion is attributed to hospital investments.<sup>100</sup> The average hospital spends a significant amount of their budget on technology investments alone, and this is only expected to increase.<sup>101</sup>

Hospital real estate business has become its own subsector of the real estate industry. While hospitals continuously expand their “off-campus medical practices and other facilities,” they also lease, rent, or partner with real estate investment trusts, which produces various streams of income.<sup>102</sup> And still, other hospitals are monetizing their real estate by undergoing mergers and acquisitions or allowing outside investment, thus providing another income stream.<sup>103</sup>

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99. See *Parish v. Pitts*, 244 Ark. 1239, 1247, 429 S.W.2d 45, 49 (1968) (describing the historic changes in operations of municipalities as “engag[ing] in fields of activity . . . never dreamed of in 1788, when this doctrine was first set forth”).

100. Margaret Patrick, *Analyzing Hospital Expenses: Breaking Down the Important Costs*, MKT. REALIST (Dec. 12, 2019, 5:45 PM), [<https://perma.cc/5B5G-BAZK>] [hereinafter *Analyzing Hospital Expenses*] (“Hospitals are a capital-intensive business with substantial investments in real estate, skilled labor, and medical equipment. According to an annual capital survey for 2012 by the U.S. Census Bureau, out of the \$90.7 billion invested in the healthcare sector, \$56.7 billion was invested in the hospital industry. . . . A total of \$47.9 billion was invested in structures and \$42.8 billion in equipment in the healthcare sector. . . . [H]uge investments [are] at stake . . .”).

101. See generally HEALTH F. & FIRST AM. HEALTHCARE FIN., EXPECTATIONS FOR QUALITY & COMPLIANCE IMPROVEMENT DRIVING STRONG TECHNOLOGY INVESTMENT BY HOSPITALS (2016), [<https://perma.cc/76LN-U5ML>]; see also Margaret Patrick, *Understanding Hospitals’ Size, Technology, and Operating Expenses*, MKT. REALIST (Nov. 26, 2019, 10:36 PM) [<https://perma.cc/5RW9-ADST>] (“According to a survey . . . by the American Hospital Association . . . , technology investments are expensive. The median annual capital investment is \$7,00,000 [sic] . . .”).

102. Susan Morse, *Hospital Chains Make Big Money in Real Estate by Unloading Properties*, HEALTHCARE FIN. (May 13, 2015), [<https://perma.cc/776S-A2YN>] (“[M]ore common is for healthcare organizations to partner with real estate investment trusts . . . . REITs are strong income producers, paying out at least 90 percent of their taxable income in the form of dividends to shareholders.”).

103. See Kelly M. Blumline et al., *6 Key Trends Affecting Healthcare Real Estate in 2017*, BECKER’S HOSP. REV. (Feb. 23, 2017), [<https://perma.cc/5CR5-WZAE>] (“In the last decade, healthcare real estate has become a more widely recognized asset class by both the

Despite filing only 8% of total charitable tax returns, charitable hospitals contributed to 93% of the total assets reported.<sup>104</sup> In Arkansas, charitable hospitals report total assets ranging from almost \$5.8 million to more than \$1.2 billion.<sup>105</sup> Hospitals are creating alternate streams of income, demonstrating that immunity is no longer necessary to ensure their continued existence because hospitals are among the “[l]arge organizations” that “dominate[] the financial activity of the charitable sector.”<sup>106</sup>

The expensive costs of new buildings and equipment arguably proves that if hospitals have not experienced bankruptcy because of such costs, it is unlikely that bankruptcy would occur should liability become a potential expense.<sup>107</sup> The vast variety and size of assets does not reflect negatively on the business of a hospital, as it is more a reflection of economic change; however, it is evidence that charitable hospitals are fully capable of being held liable for an injury they cause.<sup>108</sup> Charitable immunity’s operation in the law no longer reflects how charitable hospitals operate in modern life.

### 3. Financial Funding

Charitable immunity once provided hospitals a way to maintain their operations while providing care to low-income patients.<sup>109</sup> However, increases in state and federal funding now

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domestic and international investment community. . . . [M]any health systems and physician groups have elected to ‘monetize’ their real estate assets.”); Morse, *supra* note 102.

104. See I.R.S., STATISTICS OF INCOME, *supra* note 90 (“Charities with assets over \$10 million filed only 8 percent of the returns for Tax Year 2015, but they accounted for 93 percent of the assets . . . . While small charities filed nearly 60 percent of returns, they represented a negligible amount of the sector’s financial holdings and activity.”).

105. See *Baptist Health*, *supra* note 96; *St. Bernards Community Hospital*, *supra* note 96.

106. I.R.S., STATISTICS OF INCOME, *supra* note 90 (“Large organizations, especially hospitals . . . dominated the financial activity of the charitable sector.”).

107. See generally *Analyzing Hospital Expenses*, *supra* note 100 (“Hospitals are a capital-intensive business with substantial investments in real estate, skilled labor, and medical equipment. According to an annual capital survey for 2012 by the U.S. Census Bureau, out of the \$90.7 billion invested in the healthcare sector, \$56.7 billion was invested in the hospital industry. . . . A total of \$47.9 billion was invested in structures and \$42.8 billion in equipment in the healthcare sector.”).

108. See *supra* note 99 and accompanying text.

109. See *supra* note 27 and accompanying text.

offer ample resources.<sup>110</sup> While some charitable organizations are funded primarily by donations, the modern hospital is financed predominately by “government contracts and fee-based services.”<sup>111</sup>

The National Health Expenditure Projections for 2018-2027 predicts that the uninsured population will decrease from 2013-2016 then increase from 2018-2027, but that the total share of the insured population will remain at approximately 90%.<sup>112</sup> This makes it more likely that patients will be able to provide payment for services, resulting in consistent revenue for the hospital and the ability to obtain credit and utilize debt for operations and expansions.<sup>113</sup>

While government funds have increased for hospitals, donations remain a small contribution, thus pushing against the notion that those funds given for a charitable purpose should not be used to satisfy a judgment.<sup>114</sup> Historically, donations were predominately made by private individuals.<sup>115</sup> Today, most of the (relatively few) donations are provided by corporate donors to corporate hospitals.<sup>116</sup> Comparatively, health related organizations receive about 9% of total annual private giving.<sup>117</sup> Although slightly higher than donations to charities involving the

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110. Cf. Andrea M. Sisko et al., *National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth*, 38 HEALTH AFFS. 491, 492-93 (2019) (demonstrating an increase in national health expenditures at both the state and federal level).

111. See MORRIS ET AL., *supra* note 77, at 5 (“For example, Religious Institutions and Environment & Animal-related nonprofits are predominantly funded by philanthropy, whereas Educational Institutions, Hospitals, and Health and Human Services receive the vast majority of their funding from government contracts and fee-based services. Larger nonprofits generally receive very little of their funding – at least in percentage terms – from philanthropy.”).

112. See Sisko et al., *supra* note 110, at 493-94.

113. See MORRIS ET AL., *supra* note 77, at 7 (“Nonprofits reliant on government contracts and fee-for-service revenue . . . use debt more often . . . [and have] greater access to credit from banks or the debt capital markets. . . . [Whereas [n]onprofits more reliant on private philanthropy . . . have less debt . . .”).

114. See *supra* note 111 and accompanying text. Cf. *Mullikin v. Jewish Hosp. Ass’n of Louisville*, 348 S.W.2d 930, 930, 932-33 (Ky. 1961).

115. *Mullikin*, 348 S.W.2d at 932-33 (“[Historically,] [m]ost gifts to charity were private, not corporate. . . . [Now charity] often is corporate both in the identity of the donor and in the identity of the donee who administers the charity.” (quoting *Parker v. Port Huron Hosp.*, 105 N.W.2d 1, 12 (1960))).

116. See *id.*

117. McKeever, *supra* note 90 (table 5 demonstrates the change in charitable giving across the nonprofit sector from 2012-2017).

arts and the environment, it is considerably lower than contributions made to religion and education, at 30.9% and 14.3%, respectively.<sup>118</sup>

Unfortunately, the Tax Cuts and Jobs Act of 2017 changed the tax deductions for charitable donations.<sup>119</sup> The result has been a significant decrease in charitable giving, which is likely to continue.<sup>120</sup> In one year, contributions made by individuals decreased by six percent of the total U.S. GDP.<sup>121</sup> Consequently, with fewer individuals making contributions, donative intent is less and less relevant and should not play a role in determining liability. The corporate nature of the contributions and of the recipients alter the expectation of how monies should be utilized and who should be held accountable for their actions.

Finally, the widespread availability of hospital liability insurance negates the argument that paying damages would diminish hospital revenues from something other than charitable purposes.<sup>122</sup> Liability insurance would likely cover the cost of any injury and, if not, the modern hospital has income from sources such as investments and rent that can offset nearly any liability expense.<sup>123</sup> Although procuring insurance coverage would reduce some amount of revenue, it likely would not be financially ruinous for a hospital's operations because the cost of liability insurance is barely over one percent of all expenses.<sup>124</sup> Thus, the increased financial burden is associated with the

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118. *Id.*

119. JANE G. GRAVELLE ET AL., CONG. RSCH. SERV., R45922, TAX ISSUES RELATING TO CHARITABLE CONTRIBUTIONS AND ORGANIZATIONS (2020), [<https://perma.cc/P3P8-39CV>] (“Changes in the tax revision enacted in late 2017, popularly known as the Tax Cut[s] and Jobs Act[,] . . . while not generally aimed at charitable deductions, reduced the scope of the tax benefit for charitable giving. A higher standard deduction and the limit on the deduction for state and local taxes caused more individuals to take the standard deduction, as opposed to itemizing deductions. As a result, many individuals who were able to deduct charitable contributions no longer claim this itemized deduction. Other changes exempted more estates from the estate tax, eliminating the benefit of deducting charitable contributions in these cases. Concerns have arisen that these changes are expected to lead to a reduction in charitable contributions.”).

120. *See id.* at 1.

121. *Id.* at 27.

122. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS, *supra* note 27, § 895E cmt. c.

123. *See The Quality of Mercy, supra* note 4, at 1395.

124. *See* AM. HOSP. ASS'N, TRENDWATCH CHARTBOOK 2018: TRENDS AFFECTING HOSPITALS AND HEALTH SYSTEMS 59 (2018), [<https://perma.cc/2E6T-PYAQ>] (chart 6.10 shows the small percentage of total expenses attributed to the cost of liability insurance).

reasonable protection that comes from the cost of insurance, not the cost of damages.<sup>125</sup> The protections of charitable immunity are overbroad and cover expenses that typical liability insurance can, and ought, to cover.

#### 4. Tax Breaks (With Little to Show for It)

Charitable institutions not only benefit from increased revenue and government funding, but also take advantage of significant tax breaks as tax exempt organizations under section 501(c)(3) of the Internal Revenue Code.<sup>126</sup> Providing charity care is one way to satisfy the “community benefit standard” to meet the charitable purpose requirement,<sup>127</sup> which means that the hospital must provide some sort of health benefit to the community, among other things.<sup>128</sup>

What constitutes charity care is controversial amongst policymakers, which has caused a disparity between the actual charitable benefits provided to the public and the advantages that charitable hospitals reap from tax exemption.<sup>129</sup> There is generally no specific requirement for how much charity care must

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125. *Granger v. Deaconess Hosp. of Grand Forks*, 138 N.W.2d 443, 448 (N.D. 1965) (“What is at stake, so far as the charity is concerned, is the cost of reasonable protection, the amount of the insurance premium as an added burden on its finances, not the awarding over in damages of its entire assets.”).

126. *See generally Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3)*, IRS, [https://perma.cc/N5PE-KUL5] (last updated Sept. 19, 2020). Hospitals can be classified as tax exempt under section 501(c)(3) of the Internal Revenue Code if they are “organized or operated exclusively for exempt purposes,” which include “religious, charitable, scientific, literary, or educational” objectives. *Id.*

127. MARCO A. VILLAGRANA ET AL., CONG. RSCH. SERV., IF10918, HOSPITAL CHARITY CARE AND RELATED REPORTING REQUIREMENTS UNDER MEDICARE AND THE INTERNAL REVENUE CODE (2018), [https://perma.cc/E3TB-YEJS] (“A nonprofit hospital applying for, or seeking to maintain, tax-exempt status as a ‘charitable’ organization under IRC Section 501(c)(3) must meet a ‘community benefit standard’ developed by the IRS. . . . One way hospitals may demonstrate that they have met the community benefit standard is by providing charity care.”).

128. *Id.* (“Generally, [the community benefit] standard requires the hospital to show that it has provided benefits that promote the health of a broad class of persons to the community.”); *see also* JAMES J. FISHMAN ET AL., NONPROFIT ORGANIZATIONS: CASES AND MATERIALS 301, 303 (5th ed. 2015). To qualify as a not-for-profit hospital, the hospital must not benefit private interests and must hold an open emergency room. *Id.*

129. *See generally* Rosenthal, *Benefits Questioned*, *supra* note 82 (questioning the value of the tax exemptions that many nonprofit hospitals take advantage of because of their charitable status, which has been a growing debate among health care management, regulators, and politicians).

be provided, making it easy for hospitals to benefit from tax-exempt status with little to show for it.<sup>130</sup>

For example, the IRS permits hospitals to provide charity care through financial assistance policies.<sup>131</sup> While most charitable hospitals have some sort of policy, most hospitals fail to notify patients of their eligibility.<sup>132</sup> Moreover, the hospital has discretion in defining charity care as prescribed by their own internal policy.<sup>133</sup> Thus, the Arkansas Supreme Court is being misled by arbitrary numbers and policies described in the charities' documents. While the taxation of charities is largely out of the realm of the justice system, it is not so that reality can be ignored by the black robes.

Despite the Arkansas Supreme Court's insistence on charitable funds not being diverted for other purposes, the court is being deceived by what may be reported as charity care.<sup>134</sup> No longer are the days of traditional charity care defined by partially discounted or free services.<sup>135</sup> Instead, the IRS permits hospitals to broadly define charity to include health care insurance losses, hosting community health fairs, conducting research, and even "donating" their executives' time to serve on local community boards."<sup>136</sup> But even these activities are less charitable than expected.

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130. See VILLAGRANA ET AL., *supra* note 127 ("There are no bright-line numerical thresholds for determining whether a hospital meets the legal requirements for 501(c)(3) status . . . [N]o specific amount reported [to the IRS], by itself, [is] sufficient evidence of compliance . . .").

131. *See id.* ("The Medicare Provider Reimbursement Manual instructions for the S-10 worksheet define charity care as resulting 'from a hospital's policy to provide all or a portion of services free of charge to patients who meet the hospital's charity care policy or financial assistance policy (FAP).' This includes full or partial discounts.").

132. Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 J. HEALTH CARE ORG., PROVISION, & FIN. 1, 9 (2018) [<https://perma.cc/65GB-GR3J>] ("The cost of the hospital's financial assistance policy is what the IRS defines as the hospital's charity care on Schedule H. . . [E]xamin[ing] compliance in 2012 with these provisions . . . [demonstrates] that while almost all have established financial assistance policies, just under half notified patients of their eligibility . . .").

133. See VILLAGRANA ET AL., *supra* note 127 ("[W]hat constitutes charity care under Medicare is largely determined by an individual hospital's charity care policy . . .").

134. See, e.g., Fairchild, *supra* note 11.

135. See Rosenthal, *Benefits Questioned*, *supra* note 82.

136. *Id.* ("[T]he I.R.S. allows hospitals to use broad definitions of community service, including the value of traditional charity — care dispensed free or at a discount to those who cannot pay — and the money hospitals calculate they lose because Medicaid reimburses

Research can be, and often is, funded by various national institutes and drug companies, and community health fairs and other activities are likened to advertising and marketing for the hospital.<sup>137</sup> Of course, these things should not be undervalued because they do benefit community health—but at what cost? Almost \$25 billion and victims experiencing compounded suffering.<sup>138</sup>

The total amount of charity care provided is insignificant compared to the other expenses of a charitable hospital.<sup>139</sup> While the value of charity care given by tax-exempt hospitals is significantly more than that given by for-profit hospitals, the cost of care viewed as a percentage of operating expenses and total expenses is not substantially different.<sup>140</sup> In addition, the community benefit standards that dictate whether a hospital can be classified as not-for-profit are also “generally provided by . . . for-profit[]” hospitals.<sup>141</sup> Consequently, charity care provided compared to a hospital’s operating expenses and total expenses has decreased by approximately 23%.<sup>142</sup>

Comparing the charity care and community benefit of various charitable hospitals in Arkansas demonstrates that charitable activity is a negligible expense by hospital accounting

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them less than their costs. Hospitals can also take credit for hosting health fairs, operating some research labs and ‘donating’ their executives’ time to serve on local community boards.”).

137. See Michael A. Morrissey et al., *Do Nonprofit Hospitals Pay Their Way?*, 15 HEALTH AFFS. 132, 134 (1996) (“Hospitals may provide other community dividends such as teaching, research, preventive services, and primary care in underserved areas. . . . Substantial amounts of research are funded by the National Institutes of Health, drug companies, and other entities. The provision of screening and preventive services may be more akin to marketing efforts than to true community dividends.”).

138. Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011*, 34 HEALTH AFFS. 1225, 1225 (2015); see *supra* note 29 and accompanying text.

139. I.R.S., DEP’T OF THE TREASURY, REPORT TO CONGRESS ON PRIVATE TAX-EXEMPT, TAXABLE, AND GOVERNMENT-OWNED HOSPITALS 4 (2018), [<https://perma.cc/E5VE-XJWJ>] [hereinafter I.R.S., REPORT TO CONGRESS].

140. *Id.* As a percentage of operating expenses, for-profit hospitals’ cost of charity care is 0.94% while not-for profit hospitals’ cost is 1.64%. *Id.* As a percentage of total expenses, for-profit hospitals’ cost of charity care is 0.93% while not-for-profit hospitals’ is 1.62%. *Id.*

141. See Herring et al., *supra* note 132, at 9 (“[N]either combined community benefits nor charity care alone (whether measured as totals or incremental amounts relative to for-profits) is strongly correlated with the value of the tax exemption . . .”).

142. I.R.S., REPORT TO CONGRESS, *supra* note 139, at 10.



metrics. Overall, charity care provided by Arkansas hospitals has declined by almost half.<sup>143</sup> In Arkansas, as a percentage of total expenses, charity care ranges from 0.29% to 2.33%, while other community benefits range from 0.0% to 1.01%.<sup>144</sup> Thus, despite the name “charitable” hospital, charity care does not overtake their budget.

Further, nonprofit hospitals obtain several significant tax advantages, including avoiding federal or state corporate income tax, state sales tax, or local property taxes, amounting to more than \$12 billion in 2002 and having since more than doubled to approximately \$25 billion.<sup>145</sup> Although some charitable hospitals provide charity care that justifies their tax advantages, others do not.<sup>146</sup> Data “indicate[s] that the difference between the value of charity care alone and the value of the tax exemption averages –3.72% of total expenses” while benefits from the tax exemption average about 5.87% of expenses.<sup>147</sup> While the tax exemption may be justified in some cases, the legal exemption is not. Tax-exempt status combined with immunity from tort liability does not account for the little cost of charity care actually provided.

The minimal amount of charity care provided arguably demonstrates that perhaps the public is not benefitting from the funds held in trust. Not only are taxpayers not reaping the benefits of their contributions, they are also being penalized further by allowing hospitals to escape liability for their own actions. Thus,

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143. ARK. HOSP. ASS’N, 2019 STATISTICS, *supra* note 80, at 47 (noting the decrease in charitable care from 2013 to 2017).

144. See *White River Health System Inc.*, HOSPITALFINANCES.ORG, [https://perma.cc/HWE4-NGHB] (last visited Feb. 20, 2020); *St. Bernards Community Hospital*, *supra* note 96; *Baptist Health*, *supra* note 96.

145. See Rosenbaum et al., *supra* note 138, at 1225 (“The congressional Joint Committee on Taxation estimated the value of the nonprofit hospital tax exemption at \$12.6 billion in 2002 . . . [T]he size of the exemption reached \$24.6 billion in 2011.”); see also Morrisey et al., *supra* note 137, at 132 (“Nonprofit . . . hospitals . . . have long enjoyed favorable tax treatment. As 501(c)(3) organizations under the federal tax code, they are exempt from federal corporate income taxes. Similarly, states exempt them from state income taxes. Nonprofit hospitals typically are exempt from local property taxes and have access to tax-exempt debt. Tax-exempt debt allows hospitals to borrow money at rates that are typically two to three percentage points below those paid by equally risky enterprises.”).

146. See Rosenthal, *Benefits Questioned*, *supra* note 82 (“A study . . . in The New England Journal of Medicine found that hospitals spent an average of 7.5 percent of their operating costs on charity care and community benefit . . . . Some spent under 1 percent and others about 20 percent.”).

147. Herring et al., *supra* note 132, at 7, 9 (“The average direct and indirect benefits of the tax exemption equal 5.87% of total expenses.”).

type of business organization should neither “nullify liability altogether” nor “leave the burden of negligent injury to be borne exclusively by the victim.”<sup>148</sup>

## V. CHARITABLE IMMUNITY’S MISPLACEMENT IN THE LAW

A consistently reiterated reason for granting charitable immunity to hospitals has been the policy that the funds donated would not align with the purpose for which they were given should such funds be utilized to pay damages of a judgment.<sup>149</sup> However, this reasoning is flawed.

### A. The Charitable Purpose

Historically, the financial needs of charitable hospitals were “poorly satisfied,”<sup>150</sup> and it made sense to limit the use of monetary gifts to specifically charitable purposes rather than the satisfaction of damages.<sup>151</sup> However, as explained above, contributions are a small portion of income, while government funding and insurance, for both the hospital and the patient, have increased.<sup>152</sup> What remains are two considerations—the right of individuals to seek redress from negligence and the right of the charitable organization to use its monies for charitable purposes.<sup>153</sup>

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148. See *Albritton v. Neighborhood Ctrs. Ass’n for Child Dev.*, 466 N.E.2d 867, 869 (Ohio 1984) (“The form of legal organization may affect where liability is ultimately placed. But, in general, it does not nullify liability altogether and does not leave the burden of negligent injury to be borne exclusively by the victim.”).

149. See *supra* note 19 and accompanying text.

150. See *Mullikin v. Jewish Hosp. Ass’n of Louisville*, 348 S.W.2d 930, 932 (Ky. 1961) (“Charitable needs were always poorly satisfied.”).

151. See *id.* (“It made sense in that period to hold that all gifts to charity should go to the purposes for which they were given, and not to outsiders who were by accident injured in the administration of the charity.”).

152. See *supra* notes 111-17 and accompanying text.

153. See *Albritton*, 466 N.E.2d at 870 (“[I]t has been determined that the benefit to society as a whole from protecting charitable organizations outweighs the detriment to any one particular injured individual. . . . [The] resolution of such a question involves a balancing of two rights. On the one hand is the right of charitable organizations to any benefit and assistance which society can justly allow them. On the other hand is the right of an individual, injured by the negligence of another, to seek compensation.”).

Arguably, all monies received and expended are for the purpose of the charity without reference to how they are received. Whether it be spent on infrastructure, technology, research, salaries, or electricity, the money generated is put towards hospital operations. Granting hospitals immunity seems to place greater protection on the cash held in their trust accounts rather than individual human rights, “thus favoring property rights over personal rights.”<sup>154</sup>

The Arkansas Supreme Court has quoted authority stating that charitable trusts are made for the purpose of benefitting the public at large and include those gifts given “for the relief and comfort of the poor, the sick, and the afflicted.”<sup>155</sup> Therefore, should a hospital negligently injure one of its patients—that is, someone of the public who comes in to benefit from such charitable care—those funds donated to the charity could be a source of funds used to satisfy a tort judgment. While contributions were perhaps made for care and not reimbursement for harm, the funds should at least be made available to make injured patients whole.

The court’s view on the charitable purpose for which funds may be used is too limited. Should a hospital negligently harm a patient who is thereafter unable to support themselves, the hospital’s funds could be utilized to provide charity to the injured patient. While this may not be the typical understanding of charity care, it *is* still charity care. The public interest would be better served by holding hospitals accountable and reducing the suffering of the individual.

## B. In Opposition to Tort Law

Charitable immunity “proves itself an instrument of injustice”<sup>156</sup> from the general rule of liability for wrongdoing, and

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154. See *Garlington v. Kingsley*, 289 So. 2d 88, 92 (La. 1974) (“Charitable immunity, although apparently created as a public policy to encourage charities, actually violates the general public policy because it affords great protection to trust funds and certain other properties, thus favoring property rights over personal rights.”).

155. *Woman’s Christian Nat’l Libr. Ass’n v. Fordyce*, 79 Ark. 532, 537, 86 S.W. 417, 418 (1904) (quoting 2 Perry on Trusts, § 687).

156. *Flagiello v. Pa. Hosp.*, 208 A.2d 193, 206 (Pa. 1965) (“The charitable immunity rule proves itself an instrument of injustice and nothing presented . . . shows it to be otherwise. In fact, the longer the argument for its preservation the more convincing is the

immunity the exception.<sup>157</sup> “Tort law [seeks] to reconcile the policy of letting accidents lie where they fall, . . . giving reasonable freedom of action . . . and protection [to] the individual from injury which the [hospital] had a reasonable opportunity to avoid . . . .”<sup>158</sup> Among the traditional goals of tort law are compensation and deterrence, neither of which charitable immunity adequately satisfies.<sup>159</sup> The cost to the victim is the full burden of the injury, while the cost to the hospital, whether moral or financial, is minimal.

Charitable immunity, in its current state in Arkansas, results in “immunity from *suit*, not . . . immunity from liability.”<sup>160</sup> Immunity from suit means that charitable hospitals are free from standing trial.<sup>161</sup> In contrast, immunity from liability is merely a defense to a lawsuit.<sup>162</sup> Thus, the Arkansas Supreme Court permits charitable hospitals to be “*completely* immune from suit[,] and [they] cannot be named as a defendant.”<sup>163</sup> Although Arkansas does have a direct action statute, which allows an individual to have a cause of action against the hospital’s “insurer regardless of the fact that the actual tortfeasor may not be sued,” because the liability is the hospital’s, neither accountability for harm nor deterrence from future harm are accomplished.<sup>164</sup>

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proof that it long ago outlived its purpose if, indeed, it ever had a purpose consonant with sound law.”); *see also* Noel v. Menninger Found., 267 P.2d 934, 942 (Kan. 1954) (“It is a general principle that for negligent or tortious conduct, liability is the rule. Immunity is the exception to the rule, created by the courts which have applied it. The law’s emphasis is ordinarily on liability, not immunity for wrongdoing. The immunity of charitable corporations for torts is based upon very dubious grounds. It would seem that a sound social policy ought, in fact, to require such organizations to make just compensation for harm legally caused by their activities, under the same circumstances as individuals before they carry on their charitable activities. All persons, organizations and corporations stand on an equality before the law. All should be bound alike or excused alike.”).

157. *See Noel*, 267 P.2d at 942.

158. Parish v. Pitts, 244 Ark. 1239, 1246-47, 429 S.W.2d 45, 49 (1968) (“Tort law is intended to reconcile the policy of letting accidents lie where they fall, thereby giving reasonable freedom of action to others, and protection of the individual from injury which the defendant had a reasonable opportunity to avoid at the time.”).

159. Lisa A. Podewils, *Traditional Tort Principles and Wrongful Conception Child-Rearing Damages*, 73 B.U.L. REV. 407, 418 (1993).

160. Davis Nursing Ass’n v. Neal, 2019 Ark. 91, at 5, 570 S.W.3d 457, 460 (2019).

161. *Id.*, 570 S.W.3d at 460.

162. *Id.*, 570 S.W.3d at 460.

163. Scamardo v. Sparks Reg’l Med. Ctr., 375 Ark. 300, 304, 289 S.W.3d 903, 906 (2008).

164. *See* ARK. CODE ANN. § 23-79-210(a)(3) (2007) (“The insurer shall be directly liable to the injured person, firm, or corporation for damages to the extent of the coverage in

Immunity tends to foster neglect,<sup>165</sup> demonstrated by findings from Leapfrog, an organization that grades hospitals based on performance measures from various national data sources.<sup>166</sup> “[S]tates are ranked based on the number of ‘A’ [graded] hospitals they have compared to the total number of graded hospitals . . . .”<sup>167</sup> In Fall 2019, Arkansas was ranked number forty-two out of the fifty states with only 13.79% of Arkansas hospitals obtaining an “A” rating.<sup>168</sup> Unfortunately, Arkansas hospitals have further declined in the Fall 2020 ranking.<sup>169</sup> Arkansas’s health care system needs improvement, and there is no evidence that charitable immunity improves the quality of healthcare.

On the other hand, liability is more likely to result in “care and caution.”<sup>170</sup> It makes little sense that a nonprofit hospital “be charitable and give aid to others but . . . not compensate or aid those individuals who have been injured by it.”<sup>171</sup> Rigorous state and federal accreditation and licensing standards prove those employed in hospitals and other healthcare organizations believe

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the liability insurance policy, and the plaintiff may proceed directly against the insurer regardless of the fact that the actual tortfeasor may not be sued under the laws of the state.”).

165. See *Miss. Baptist Hosp. v. Holmes*, 55 So. 2d 142, 156 (1951) (“[I]t should be said that the tendency of immunity is to foster neglect . . . .”).

166. The Leapfrog Grp., *About the Grade*, LEAPFROG HOSP. SAFETY GRADE, [https://perma.cc/NLG6-4NH5] (last updated Dec. 14, 2020) (“The Safety Grade is becoming the gold standard measure of patient safety, cited in MSNBC, *The New York Times*, and AARP The Magazine. The Leapfrog Hospital Safety Grade uses up to 27 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey and information from other supplemental data sources. Taken together, those performance measures produce a single letter grade representing a hospital’s overall performance in keeping patients safe from preventable harm and medical errors. The Leapfrog Hospital Safety Grade methodology has been peer reviewed and published in the *Journal of Patient Safety*.”).

167. The Leapfrog Grp., *State Rankings*, LEAPFROG HOSP. SAFETY GRADE, [https://perma.cc/MS8Z-7939] (last updated Dec. 14, 2020) [hereinafter *State Rankings*].

168. *Id.*; see also The Leapfrog Grp., *How Safe is Your Hospital?*, LEAPFROG HOSP. SAFETY GRADE, [https://perma.cc/JH4M-7TDG] (last updated Dec. 14, 2020) (choose “Search By City/State”; then choose “AR”; then click “Search”) (reviewing detailed grades for respective Arkansas hospitals).

169. *State Rankings*, *supra* note 167 (ranking Arkansas 46 out of 50 states with just 6.90% of Arkansas hospitals obtaining an “A” rating).

170. See *Holmes*, 55 So. 2d at 156 (“[T]he tendency of imposing liability is to induce care and caution in the treatment of those for whom these institutions were established.”).

171. *Albritton v. Neighborhood Ctrs. Ass’n for Child Dev.*, 466 N.E.2d 867, 870 (Ohio 1984) (“Indeed, it is almost contradictory to hold that an institution organized to dispense charity shall be charitable and give aid to others but shall not compensate or aid those individuals who have been injured by it.”).

that it is “both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.”<sup>172</sup>

Hospitals do not run without employees, and medical professionals cannot operate without hospital facilities. The two are not mutually exclusive and both should be bound by the functions of tort law. Charitable immunity unjustly affects an individual’s right to relief from those who caused the injury and should no longer be a defense that hospitals can assert against individuals in the courtroom.

## VI. ARKANSAS DOCTRINE

Arkansas’s charitable immunity doctrine continues to operate “in a jurisprudential landscape of shifting sands.”<sup>173</sup> From the drastic changes in the case law to the lack of clarity in applying the eight-factor test, the courts have seen no stability or consistency despite what their “rule of property” hoped to ensure.<sup>174</sup> The Arkansas Supreme Court must prospectively abrogate the doctrine of charitable immunity in light of the reality surrounding the modern hospital and establish clarity for practitioners.

### A. Arkansas’s (Significant) Issues

The purpose for which charitable immunity was recognized in Arkansas was to prevent charitable institutions from “hav[ing] their assets diminished by” paying damages.<sup>175</sup> As demonstrated above, the reality is that the modern charitable hospital has “trust

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172. *Darling v. Charleston Cmty. Mem’l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (“The Standards for Hospital Accreditation, the state licensing regulations and the defendant’s bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.”).

173. *Felton v. Rebsamen Med. Ctr., Inc.*, 373 Ark. 472, 486, 284 S.W.3d 486, 496 (2008) (Brown, J., dissenting).

174. *See Helton v. Sisters of Mercy of St. Joseph’s Hosp.*, 234 Ark. 76, 81, 351 S.W.2d 129, 131 (1961).

175. *See Sowders v. St. Joseph’s Mercy Health Ctr.*, 368 Ark. 466, 470, 247 S.W.3d 514, 517 (2007) (quoting *George v. Jefferson Hosp. Ass’n*, 337 Ark. 206, 211, 987 S.W.2d 710, 712 (1999)).

attributes” with interests in many businesses and real estate, operating on daily “commercialized transactions.”<sup>176</sup>

The Arkansas Hospital Association reports that it saved more than \$47 million in costs and helped generate over \$26 million in revenue for Arkansas hospitals while, simultaneously, the provision of charity care decreased by 44%.<sup>177</sup> Notably, the court recognizes that the “modern hospital . . . would find it extremely difficult to operate wholly or predominately on charitable donations.”<sup>178</sup> Presumably, the court is aware of the vast availability of financial funds hospitals have at their disposal to pay a judgment. Thus, tort liability would not deplete the hospital’s funds, which is the entire “essence of the [charitable immunity] doctrine.”<sup>179</sup> Yet, the court continues to value the importance of charitable hospitals and their financial gain over the importance of essential principles of tort law—making a victim whole.<sup>180</sup>

### 1. *Judge v. Jury*

For charitable immunity to apply, the hospital must satisfy the *Masterson* eight-factor test adopted by the Arkansas Supreme Court, which asks:

- (1) whether the organization’s charter limits it to charitable or eleemosynary purposes;
- (2) whether the organization’s charter contains a “not-for-profit” limitation;
- (3) whether the organization’s goal is to break even;
- (4) whether the organization earned a profit;
- (5) whether any profit or surplus must be used for charitable or eleemosynary purposes;
- (6) whether the organization depends on contributions and donations for its existence;
- (7) whether the

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176. See *supra* notes 99-108 and accompanying text; *Crossett Health Ctr. v. Crosswell*, 221 Ark. 874, 883, 256 S.W.2d 548, 552 (1953).

177. ARK HOSP. ASS’N, 2019 ANNUAL REPORT 9, 11 (2019), [<https://perma.cc/HL3W-WKQF>]; ARK. HOSP. ASS’N, 2019 STATISTICS, *supra* note 80, at 47.

178. *Scamardo v. Sparks Reg’l Med. Ctr.*, 375 Ark. 300, 308, 289 S.W.3d 903, 908 (2008) (quoting *George*, 337 Ark. at 214, 987 S.W.2d at 714).

179. *Sowders*, 368 Ark. at 470, 247 S.W.3d at 517 (quoting *George*, 337 Ark. at 211, 987 S.W.2d at 712).

180. See *Adkins v. St. Francis Hosp. of Charleston, W. Va.*, 143 S.E.2d 154, 162 (W. Va. 1965) (“One of the[] obligations [of a charitable corporation] is to make legally whole one who is injured by reason of the negligent act of its agents or employees. It makes no difference whether the injured party is a paying patient or one who is being served without charge.”).

organization provides services free of charge to those unable to pay; and (8) whether the directors and officers receive compensation.<sup>181</sup>

The court has since expounded on some of the factors;<sup>182</sup> however, the issue of who is to decide the application of the factors is often litigated.<sup>183</sup> *Undisputed* facts are to be decided by the court while *disputed* facts are presented to the jury.<sup>184</sup> When the facts are *undisputed* but subject to *differing legal interpretations*, the court determines the charitable standing of the hospital and grants summary judgment when reasonable minds would not differ based on those facts.<sup>185</sup> However, allowing the judge to determine “issues of fact” from “legal interpretation[s] of undisputed facts,” . . . runs counter to the foundational principle in our jurisprudence that juries are fact-finders—not the judges.”<sup>186</sup>

Ironically, despite the claim that hospitals determined to be charitable are immune from suit, should the facts be disputed, the hospital is not actually immune from suit. The issue of charitable status is presented to the jury, and thus, “a substantial portion of the defendant’s immunity from suit is lost by this process, regardless of the outcome.”<sup>187</sup> The point of the parties coming before the court on the issue of charitable status is because they, in fact, do have reasonably differing views and interpretations of whether the hospital qualifies as charitable. The ultimate question of whether the hospital is a charity is a factual inquiry.<sup>188</sup> Despite the application of the factors and outcomes that have come before the court, reasonable minds could, and often do, differ.<sup>189</sup>

Initially, the court interpreted the charitable immunity doctrine narrowly—often forgoing charitable immunity status by

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181. *Masterson v. Stambuck*, 321 Ark. 391, 400-01, 902 S.W.2d 803, 809-10 (1995) (explaining that the court adopted the eight-factor test from the Eastern District of Virginia).

182. *See Scamardo*, 375 Ark. at 307-09, 289 S.W.3d at 907-09; *see also Anglin v. Johnson Reg’l Med. Ctr.*, 375 Ark. 10, 16-18, 289 S.W.3d 28, 31-33 (2008).

183. *See Scamardo*, 375 Ark. at 309, 289 S.W.3d at 909.

184. *See supra* note 39 and accompanying text; *Davis Nursing Ass’n v. Neal*, 2019 Ark. 91, at 6-8, 570 S.W.3d 457, 461-62.

185. *Davis*, 2019 Ark. 91, at 6-7, 570 S.W.3d at 461 (quotations omitted) (citing *Anglin*, 375 Ark. at 21, 289 S.W.3d at 35).

186. *Anglin*, 375 Ark. at 22, 289 S.W.3d at 36 (Brown, J., dissenting).

187. *Davis*, 2019 Ark. 91, at 8, 570 S.W.3d at 462 (Wood, J., concurring).

188. *Anglin*, 375 Ark. at 22, 289 S.W.3d at 36 (Brown, J., dissenting).

189. *See, e.g., id.* at 22-23, 289 S.W.3d at 36.



evaluating a few of the factors later established in *Masterson*.<sup>190</sup> However, the court eventually broadened its application by evaluating more factors.<sup>191</sup>

Factors (1) and (2) consider the organizational documents of the institution and, essentially, take their mere words at face value.<sup>192</sup> Simply because the Articles of Incorporation limit the hospital to charitable purposes or its classification to tax-exempt has little bearing on how the hospital appears to function to outside observers. As explained previously, charitable hospitals do the minimum to comply with IRS guidance.<sup>193</sup> By strictly resorting to the words claimed on the page, the courts are being misled, and thus, causing considerable harm to application of the law.

Next, the court provides little guidance on factors (3) and (4), which consider the financial history of the hospital.<sup>194</sup> In one case, the court determined a hospital's goal was not to break even simply because it operated at a loss of less than one percent.<sup>195</sup> In another case, the court granted charitable immunity to a hospital that made "a net profit in most years" and had "over six million dollars in reserve funds."<sup>196</sup> Again, we see the court taking words at their face value when evaluating factor (5) in that the hospital stated they used their surplus funds for charitable purposes but failed to elaborate or provide evidence of how that was accomplished.<sup>197</sup> Although charitable institutions can be profitable and such profits are not inured for private benefit, the

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190. See *Williams v. Jefferson Hosp. Ass'n*, 246 Ark. 1231, 1235, 442 S.W.2d 243, 244 (1969) (quoting *Hot Springs Sch. Dist. v. Sisters of Mercy*, 84 Ark. 497, 500, 106 S.W. 954, 955 (1907)); *Masterson v. Stambuck*, 321 Ark. 391, 401, 902 S.W.2d 803, 809-10 (1995).

191. *Williams*, 246 Ark. at 1235, 442 S.W.2d at 244-45 (citing *Helton v. Sisters of Mercy of St. Joseph's Hosp.*, 234 Ark. 76, 351 S.W.2d 129 (1961)).

192. See *Masterson*, 321 Ark. at 401, 902 S.W.3d at 809; see, e.g., *George v. Jefferson Hosp. Ass'n*, 337 Ark. 206, 212, 987 S.W.2d 710, 713 (1999) (stating that "[t]he first and second [factors] are perhaps the easiest of the factors to demonstrate as they are merely a matter of possessing corporate documentation").

193. See *supra* note 130 and accompanying text.

194. See *Masterson*, 321 Ark. at 401, 902 S.W.3d at 809.

195. *Scamardo v. Sparks Reg'l Med. Ctr.*, 375 Ark. 300, 307-08, 289 S.W.3d 903, 908 (2008).

196. *Anglin v. Johnson Reg'l Med. Ctr.*, 375 Ark. 10, 22, 289 S.W.3d 28, 36 (2008) (Brown, J., dissenting).

197. *Jackson v. Sparks Reg'l Med. Ctr.*, 375 Ark. 533, 540, 294 S.W.3d 1, 5 (2009) (explaining that the affidavit stated that any surplus funds are used for charitable purposes).

retained profits are used for its charitable purpose, which, as a hospital, is to provide care for the injured. This should be the case no matter how the patient is injured.

Notably, factor (6) should be eliminated—whether the organization depends on contributions and donations for existence has largely become irrelevant. While this factor would make a difference should hospitals actually be funded largely by private contributions, the modern hospital is not, and this factor rarely impacts whether charitable immunity is or is not granted.<sup>198</sup> The court has recognized that charitable hospitals largely do not run on contributions and donations because they have access to government financing and can seek payment from private insurers.<sup>199</sup> This alone negates the entire purpose for which charitable immunity was first recognized—that the assets held in trust only be used for their charitable purpose.<sup>200</sup> Nonetheless, the court has stated that receiving funds from other sources does not “negate its overriding charitable purpose.”<sup>201</sup>

While factor (7) is still somewhat applicable in that charitable hospitals do provide *some* services free of charge to those unable to pay, it is an insignificant portion of whom that they provide services to.<sup>202</sup> It is not likely that charitable hospitals would cease treating indigent patients should immunity be eliminated. To satisfy IRS guidance, these requirements still must be maintained, and there is no evidence that hospitals in states that have long ago abrogated the doctrine fail to treat patients despite their inability to pay.<sup>203</sup>

Finally, factor (8), the amount in which directors and officers are compensated, shows no indication of weighing against the hospital.<sup>204</sup> The court recognizes that the modern hospital is large, complex, and needs well-qualified personnel; therefore, being well compensated is the only reasonable way to obtain

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198. *See id.* at 541, 294 S.W.3d at 5.

199. *See Scamardo*, 375 Ark. at 308, 289 S.W.3d at 908.

200. *George v. Jefferson Hosp. Ass’n*, 337 Ark. 206, 211, 987 S.W.2d 710, 712 (1999).

201. *Id.* at 214, 987 S.W.2d at 714.

202. *See discussion supra* Part IV.A.4.

203. *See discussion supra* Part IV.A.4.

204. *See Anglin v. Johnson Reg’l Med. Ctr.*, 375 Ark. 10, 23, 289 S.W.3d 28, 37 (2008) (Brown, J., dissenting).

someone who can handle hospital business.<sup>205</sup> It is unlikely hospitals will become smaller or less complex and need less-qualified personnel. Thus, high compensation will likely always be justified.

Consequently, there is no clear or sound application of these factors. It seems that, by adopting these factors so long ago, the court avoided the inevitable—abolishing the doctrine.<sup>206</sup>

## 2. *Prolonging the Outcome*

When hospitals are denied charitable immunity at the trial court level, appellate courts will review the decision on interlocutory appeal, even though denied motions for summary judgment are “neither reviewable nor appealable.”<sup>207</sup> The stated reasoning behind doing so is that immunity from suit would otherwise be lost.<sup>208</sup> However, the hospital going through the appeals process is evidence of the fact that immunity from suit is already lost. Justice Baker correctly notes that a failure to recognize charitable immunity status by a denied summary judgment order does not, in fact, discontinue the action and result in a final, appealable order.<sup>209</sup> The medical malpractice claim actually continues and, like all other individuals and businesses, the hospital will have the opportunity to take advantage of the appeals process at the conclusion of litigation.<sup>210</sup>

By permitting this to occur, the court is causing unnecessary administrative burden on itself and the parties involved—as well as prolonging a determination of the underlying issues of the tort claim. “[T]he purpose of a final order,” of which this is not, “is to avoid piecemeal litigation.”<sup>211</sup> Claims of this nature add years

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205. *George v. Jefferson Hosp. Ass’n*, 337 Ark. 206, 214, 987 S.W.2d 710, 714 (1999) (explaining that the “size and complexity [of hospitals] make knowledgeable, well-qualified personnel essential”).

206. *See Masterson v. Stambuck*, 321 Ark. 391, 400, 902 S.W.2d 803, 809 (1995).

207. R. F. Chase, Annotation, *Reviewability of Order Denying Motion for Summary Judgment*, 15 A.L.R. 3d 899 (1967).

208. *Id.*

209. *Davis Nursing Ass’n v. Neal*, 2019 Ark. 91, at 9, 570 S.W.3d 457, 462 (Baker, J., dissenting).

210. *Id.*, 570 S.W.3d at 462 (Baker, J., dissenting).

211. *Id.* at 10, 570 S.W.3d at 463 (Baker, J., dissenting).

onto the litigation process and are an injustice to practitioners and individuals.<sup>212</sup>

## VII. CONCLUSION

There is no justification for continued adherence to charitable immunity. Arkansas is one of the last states to recognize this antiquated doctrine, which only serves as an injustice in the legal system.<sup>213</sup> The Arkansas Supreme Court has one choice: continue to give favorable treatment in the courtroom to the commercial business of charitable hospitals or allow justice to precede generosity.

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212. *See id.* at 9, 570 S.W.3d at 462 (Baker, J., dissenting); *Masterson v. Stambuck*, 321 Ark. 391, 394, 902 S.W.2d 803, 806 (1995).

213. *See supra* note 36 and accompanying text.